Cabinet for Health and Family Services
Secretary's Advisory Committee on Health Care Transparency

Tuesday, March 28, 2006
1 – 3 p.m.
Salato Wildlife Center
Frankfort, Kentucky

AGENDA

I. **Welcome**

II. **Business Items**

   a. **Roll Call**
   b. **Approval of Minutes**

III. **Data Advisory Subcommittee Report**

IV. **Legislative Update**

   a. **State Legislation (HB445, HB622, Budget Bill)**
   b. **Federal Initiatives**

V. **Overview of Data Resources**
   a. **Federal & National Level Sources**
   b. **State Examples**

VI. **Discussion of Website Prototype**

VII. **Next Steps**

   a. **Review of Action Items**
   b. **Date of Next Meeting**

SECRETARY'S ADVISORY COMMITTEE ON HEALTHCARE TRANSPARENCY MEETING
March 28, 2006
1:00 p.m.

MEMBERS PRESENT:

Larry Bone
Four Rivers Health Care Purchasing Alliance

Victor Cooper, DC
Cooper Chiropractic Center

Chris Corbin
Office of Health Policy

Tom Granatir
Humana, Inc.

Frank Jemley
Atticus Ventures, LLC

Glenn Jennings
Office of Insurance

John Lewis, MD
Health Care Excel

Dustin Miller
Kentucky Association of Health Plans

Pat Padgett
Kentucky Medical Association

Bill Tatum
Angell-Denham

Ben Yandell
Norton Healthcare

Elizabeth Cobb (on behalf of Paige Franklin)
Kentucky Hospital Association

Greg Coulter (on behalf of John Burt, EdD)
Department for Mental Health and Mental Retardation

MEMBERS ABSENT:

John Burt, EdD
Department for Mental Health and Mental Retardation

William Hacker, MD, FAAP, CPE
Department for Public Health

Paige Franklin
Kentucky Hospital Association

Lawrence Kissner
UnitedHealthcare

Shannon Turner
Department for Medicaid Services

Marty White
Kentucky Medical Association

STAFF: Cabinet for Health and Family Services, Office of Health Policy
Mark Fazey, Sheena Lewis, Tricia Okeson, Beth Sanderson, Jodie Weber

GUESTS: Bill Doll, Kentucky Medical Association
Tim Snyder, Humana, Inc.
Dan Varga, Kentucky Medical Association
Nancy Galvagni, KHA

CALL TO ORDER

Chris Corbin called the meeting to order at the Salato Wildlife Center.

WELCOME AND OPENING REMARKS

APPROVAL OF MINUTES

Minutes from the meeting of January 4, 2006 were approved without change.

DATA ADVISORY SUBCOMMITTEE REPORT

Transparency: Reporting Hospital Charges Meaningfully, Mark Fazey presented the results of his search on the internet for hospital discharge data using a "consumer" point of view. This presentation was made to the Data Advisory Subcommittee at the February 2, 2006, meeting. Copies of presentation slides were distributed prior to the meeting.

Interesting points of Mark's presentation were:

- Texas has charge data; however, their dataset must be purchased.
- Florida's data is risk adjusted but the process is not explained very well. The average consumer might not understand.
- HCUP results are lower because it is not specific. It is not possible to "drill down" into the data.

In conclusion, Mark stated that KCHFS should focus on the consumer and the Kentucky Hospital Association should focus on the researcher/health care professional.

Ben Yandell added that during the Data Advisory Subcommittee meeting, the question of using adjusted charges to get closer to cost was raised. What is useful information for consumers?

Tom Granatir asked if reporting charges had been taken off the table. Charges are still a possibility. It is agreed that charges are hard for consumers to understand but charges are not meaningless.

Dr. John Lewis asked if the committee is interested in value measure. Tom Granatir stated that we should be.

Chris Corbin announced that the next Data Advisory Subcommittee meeting will be held in May.

LEGISLATIVE UPDATE

Chris Corbin provided a legislative update on HB 445 and HB 622. Transparency initiatives proposed in HB 445 taken out by the House have been reinstated by a Senate Committee Substitute. The bill has not been passed at this time.

HB 622, sponsored by Tom Burch, made it out of the House but has not been introduced in the Senate. HB622 also includes language regarding transparency.
Dustin Miller stated that HB 583 should also be included in the legislative update. This bill was also sponsored by Tom Burch.

Tricia Okeson updated the committee on several Federal initiatives regarding health care transparency. President Bush discussed transparency in the State of the Union speech in January. Other federal initiatives include "Payer Power" plan and CMS initiatives to make information more available to consumers. CMS also has implemented pay for performance pilot projects for hospital and physician care. A congressional hearing on health care transparency was held on March 14, 2006.

OVERVIEW OF DATA RESOURCES

Quality indicators are part of the state's proposed legislation regarding transparency but have not been discussed by the Secretary's Advisory Committee. Mark Fazey provided examples of state snapshots, showing how Kentucky compares to other states and the overall performance. Several examples were distributed in the packet prior to the meeting.

Ben Yandell added data is available now, however there is no comparative data and it is not risk-adjusted. Elizabeth Cobb stated that KHA will be releasing Inpatient Quality Indicators (IQI) on their website by the end of May. Tom Granatir proposed looking into data collection beyond hospitalization data. Dr. John Lewis stated that it would be useful to have all plans merge their data statewide. CMS data included in packet does not drill down any further than the state itself. Reports were not specific enough to help consumers.

Frank Jemley stated that charge and out-of-pocket cost is important for consumers to know.
Tom Granatir – most people aren't shopping around for the cheapest hospital.
Dan Varga suggested that insurance plans could provide best estimate of out-of-pockets expenses.
Tom Granatir stated that hospitals are acutely aware of what other hospitals are doing. They investigate then adjust accordingly. Hospitals and physicians are interested in this data. Bill Tatum suggested focusing on the best value rather than best cost. Best quality needs to drive this process.

Glenn Jennings proposed putting a calculator on the website so consumers would be able to make an educated guess on costs.

Chris Corbin pointed to Florida as an example of the robustness of data. Ben Yandell stated what Mark has presented is what the government is putting out there. There are many other proprietary sites that provide inaccurate numbers.
Chris Corbin asked the committee if there were any sites that were worth exploring. Tom Granatir mentioned New Hampshire.

John Lewis asked if patient satisfaction was included on any of the websites that were presented today. Mark said that there was not. Tom Granatir stated that perception is important. Whose perception is more important, that of the doctor or the patient? The patient's perception should be the most important.

Chris asked the group what they felt we should focus on next. He suggested taking some of the websites that were shown today and choosing what we want and what we like to try to create a starting point. Dan Varga stated on a policy level, be proscriptive of what we put into the report. Report should include what is important. Using other states quality indicators is a good idea. John Lewis said that he felt that KHA's use of median is better than Florida's use of charges.

Chris suggested and the committee agreed to allow the cabinet to create a web prototype. As a result, the timing of the next scheduled quarterly meeting may be delayed.

DISCUSSION OF WEBSITE PROTOTYPE

A prototype for the website will be available before the next meeting.

ADJOURNMENT

The meeting was adjourned at 2:55 p.m.

Transparency: Reporting Hospital Charges Meaningfully

Mark Fazey
KCHFS/OHP
February 2, 2006

- KRS 216 set the stage for transparency
  - Report cost, quality, and outcome data by hospital and payer(?)
  - Use understandable language
  - Enable consumers to draw meaningful comparisons

- To meet KRS transparency criteria, information should be
  - Timely
  - Specific
  - Comparative
  - Clearly explained
  - Easily obtained

- Search for hospital charge information
  - WI, UT, TX, FL, MA, HCUP, KY
  - Consumer point of view
  - Specific procedure (total hip replacement)
- Evaluate (unscientifically) based on criteria
  - Scale of 1(low) to 3 (high)
  - Subjective, biased, and incomplete
- Design a KCHFS approach
  - Include the "good stuff", avoid the "bad stuff"

- Results

Criterion	WI	UT	TX	FL	HCUP	KY*
Timely	1	2	N/A	2	1	2
Specific	3	3	N/A	3	2	2
Comparative	2.5	2	N/A	3[R]	2	3[S]
Clear	2	2	N/A	2	2	3
Easily obtained	3	1	N/A	2	2	3
TOTAL	11.5	10	N/A	12	9	13

[R]Risk-adjusted; [S]Reported by severity level

Cabinet for Health and Family Services

- Conclusions
  - KCHFS: focus on consumer ⇨ KHA: focus on researcher/health care professional
  - Leading elective surgeries (IP) by severity level, hospital, payer (>20 cases); leading elective OS procedures by hospital, payer (>20 cases)
  - Median and high-low percentiles (vs. mean, SD)
  - Two phases
    - Prepared tables (e.g. MA, KY Annual Utilization Reports)
    - Query system

Cabinet for Health and Family Services

kaisernetwork.org

Kaiser Daily Health Policy Report

Friday, March 17, 2006

Capitol Hill Watch

House Health Subcommittee Hearing Examines Bush Administration Effort To Increase Price Transparency

The House Energy and Commerce Subcommittee on Health on Wednesday held a hearing on the potential effects of increased price transparency for health care providers, *CQ HealthBeat* reports. Supporters said that increased price transparency will help consumers make health care decisions and lead to reduced costs. House Energy and Commerce Committee Chair Joe Barton (R-Texas) said, "Instead of a marketplace, we have a system that prevents patients from seeing how much their health care services actually cost. The health care system hides prices, and it blurs quality." Former House Speaker Newt Gingrich (R-Ga.), founder of the Center for Health Transformation, added, "Health care is the only area of America's economy where the consumer and the provider have no idea what the good and services they trade cost." However, opponents said that increased price transparency will not address the issues of high health care costs and the uninsured. Rep. Henry Waxman (D-Calif.) said that increased price transparency "is no substitute for real coverage," adding that individuals enrolled in group health plans receive lower prices than those who purchase health care on their own. In addition, he said that increased price transparency might shift more health care costs to individuals. Paul Ginsberg, president of the Center for Studying Health System Change, said, "Consumers' experiences with markets for self-pay services ... have been romanticized and do not offer much encouragement as a model of effective shopping for health care services." Rep. Sherrod Brown (D-Ohio) also said that increased price transparency should include health insurers and pharmaceutical companies, as well as providers (Carey, *CQ HealthBeat*, 3/15).

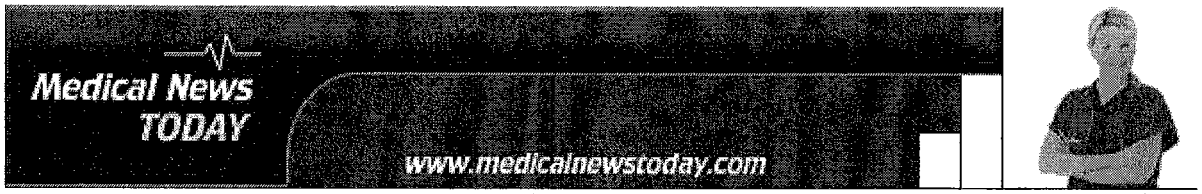
Price Disclosure Examined

In related news, the *Washington Post* on Friday examined the Bush administration's plan in the coming weeks to post online the prices that Medicare pays for common medical procedures. The published rates are part of a larger initiative to disclose price and quality data from hospitals, a plan the administration says will allow consumers to compare prices at different hospitals and decrease costs. In the next few months, the government also will post online rates negotiated by the Defense Department, the Federal Employees Health Benefits Program and private health plans in six communities. CMS Administrator Mark McClellan said hospitals will be required in 2007 to release mortality data on common illnesses, such as heart attacks and infection. According to the *Post*, some advocates for the poor say the published prices "will pressure hospitals to give uninsured patients the discounts provided to people with insurance." HHS Secretary Mike Leavitt said, "When people have information on price and quality, whether it's an individual consumer or a corporate payer, they'll be a better informed consumer." He added, "Prices will go down, and quality will go up. That happens whenever a competitive market is fully informed." However, Rick Pollack, executive vice president of the American Hospital Association, said the plan will not lower costs because, "[o]n average, Medicare pays less than the cost of delivering the

service" (Connolly, *Washington Post*, 3/17). *The Hill* on Wednesday also examined the administration proposal, which has "not been warmly received by the hospital sector" (Young/McCormack, *The Hill*, 3/15).

Opinion Piece

"A more transparent pricing system would help give providers and patients more control over their health care dollar," Rep. Michael Burgess (R-Texas) writes in a *Washington Times* opinion piece, adding, "Patients with portable health care dollars that can be paid at point of service are extremely attractive to most health care providers who normally have to wait for an insurance company" to reimburse them. Burgess writes that a lack of price transparency "has created a system where customers don't have the ability to hold providers and payers accountable" and has led to "double-digit cost increases" annually. According to Burgess, the "opportunity to plug into a fully transparent system would transform the American health care system in a radical manner, improving care for all Americans, rich and poor" (Burgess, *Washington Times*, 3/16).



CQ HealthBeat Examines Bush Administration Plan To Improve Price Transparency; HealthGrades Offers Price Reports For A Fee

22 Mar 2006 Click to Print

CQ HealthBeat on Friday examined the Bush administration's plan to disclose price and quality data from health care providers. According to HHS Secretary Mike Leavitt, government analysts will examine claims data from Medicare, Medicaid, the Department of Defense and Federal Employee Health Benefits programs so that "price and quality data will be available for each hospital and doctor." The initiative, called the "Payer Power" plan, aims to publish the total costs of procedures, although insured patients pay a fraction of those costs on the Medicare Web site. In addition, HHS will analyze six metropolitan markets, after which Leavitt will ask the markets' largest employers to join the federal government's program to try to influence health care providers to provide pricing and quality information. Health care providers and insurers would have to disclose the quality and prices of their care for 20 of the most common medical procedures in order to conduct business with the participating employers. The program, which aims to promote health savings accounts, also will try to pressure providers to adopt health information technology, according to *CQ HealthBeat*.

Leavitt's Comments

According to Leavitt, who spoke on Tuesday at the Commonwealth Club in San Francisco, pricing information could help uninsured individuals bargain with care providers for better deals. Leavitt added, "Take hip replacement surgery, for example. It would change the health care world if people could know, before their operation, what the overall package price is going to be, including lab tests, anesthesia, rehab costs, as well as specific information on quality, such as complication rates and patient satisfaction." He said, "As first steps toward full electronic health records, insurers, administrators and providers will be asked to use an interoperable electronic registration system that will do away with the medical clipboard as we know it." Leavitt continued, "We would like payers to make health savings accounts a voluntary option on their menu of health insurance plans. That will be a very important and a powerful step forward. There are currently 3.5 million people who have adopted health savings accounts and that trend will grow" because "more people will buy insurance when it is $300 a month than when it is $600 a month. It's as simple as that" (Reichard, *CQ HealthBeat*, 3/17).

Price Data for Sale?

In related news, a Colorado company on Monday began selling price data through its Web site for 42 medical procedures, the AP/Long Island *Newsday* reports. According to the *AP/Newsday*, HealthGrades will generate a detailed cost report for a procedure based on ZIP code, age, gender and insurance for $7.95. The reports include expected out-of-pocket costs for insured patients, average price negotiated by health insurers in the region and the average amount charged by the provider, according to Scott Shapiro, a spokesperson for HealthGrades. He said, "What this helps an individual do is to shop for health care, which is a very new concept. But because individuals are paying an increasing amount from out of pocket for their health care, they are increasingly looking for information that helps them shop for health care" (Sarche, AP/Long Island *Newsday*, 3/20).

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Cover Story *>> Written by Matthew DoBias*

Lifting the lid off of pricing

With HHS moving to post what it pays for common procedures, the debate over healthcare pricing transparency is heating up

Story originally published March 20, 2006

Last week, in policy and in practice, the idea that the general public should be able to see the actual costs of certain medical procedures became Topic A in Washington, with federal lawmakers, policy shapers and physicians facing off over the issue in public hearings and private meetings.

As the capper to a week that saw healthcare get a congressional workout on Capitol Hill, HHS Secretary Mike Leavitt announced that for the first time, Medicare, Medicaid and other federal agencies would be required to post the prices they pay for some very routine clinical procedures on a Web site as the first step of a larger initiative championed by the Bush administration and many in the Republican leadership.

It proved to be the fulfillment of a promise by the federal government to lead by example on the issue, and it expects hospitals and the provider community to follow that lead -- like it or not.

"People don't have a clue what they are paying and have no way of knowing how it compares to what the person in the next room is paying, let alone in the next hospital," Leavitt said in a prepared statement. "People deserve to know."

While much of Capitol Hill has taken up the issue recently in public and private forums, federal lawmakers have found themselves debating not so much over whether or not prices should be made known-most agree that they should-but at a deeper level, they want to know the motive.

Steppingstone to HSAs

Many health policy analysts see the latest push to make healthcare costs widely known as a steppingstone toward making health savings accounts -- President Bush's preferred method of insurance-a mainstay on the healthcare front.

According to the latest reports, only about 3 million Americans use the high-deductible plans. But that number is growing fast, with many major companies increasingly embracing the concept as a way to lower skyrocketing health costs. Posting price and quality data, they say, will help speed the process.

The administration's push has been strong enough to draw questions even by some in favor of clearer pricing. A family physician and consultant from Charlottesville, Va., who testified on behalf of fuller disclosure of pricing, David MacDonald, said he's no fan of Washington politics -- especially when it comes to the issue of transparent pricing. He chided the event in an interview afterward as more about making HSAs work and less about clear and

understandable costs.

"If I knew that's what it was going to be about, I wouldn't have agreed to testify," he said.

"The dilemma we face here is that we're not having a rational discussion about what would be the best source for the consumer," said Chip Kahn, president of the Federation of American Hospitals. "We are not separating one consumer from the other."

And that's a problem, Kahn said, because varying factors, such as the type of coverage a person has and how they enter the healthcare system, play a major role in the cost infrastructure.

Simplistic discussion

Kahn said that the current discussion between policymakers is overly simplistic. "It's based on the simple notion that having some kind of price information available will aid consumers in making better choices," he said. But that may not be the case. "The way people are insured and the way that they pay may" not allow that to work, he said.

Economist Paul Ginsburg, president of the Center for Studying Health System Change, said he thinks he knows why the discussion has become so polarized: "This is not an obvious policy issue."

Ginsburg, who was one of seven health leaders called to testify before a House subcommittee last week, said that the debate among lawmakers tends to mask the complexity of shifting healthcare costs to the consumer from plans and payers. "It's not really about price transparency by itself," he said. "This is just a way to joust on bigger issues, like HSAs."

Regardless of the reasoning, Leavitt's announcement was a clear signal that the Bush administration plans to lead by example when it comes to pushing hospitals and physician offices for more transparent pricing of healthcare services.

In testimony at the hearing, former House Speaker Newt Gingrich lashed out at the industry's effort to protect their pricing data, citing the example of one devicemaker who is using the courts to keep such pricing information under wraps. It's a practice that would stop if Gingrich has his druthers -- and ideally, he said, it would preclude the government from contracting with companies that don't make their costs transparent.

In one instance, Gingrich said, a device vendor has been quick to claim that pricing information is a trade secret and that hospitals that buy its devices may not disclose the information to the doctors who use them, the private payers who reimburse them or the patients who receive them.

"The inevitable result is that no price shopping can take place and price competition -- a fundamental market force -- can't take root," he said in his statement to Congress.

At a briefing earlier this month and in speeches, Gingrich repeatedly ribbed the federal government for enabling a healthcare system he sees as archaic. Because of his stature, he is one of the few people who can praise Leavitt and CMS Administrator Mark McClellan, yet at the same time take jabs at them by calling the CMS "inherently a Soviet-style command bureaucracy."

`Better access, fewer mistakes'

Gingrich said he favors moving healthcare toward a free-market model, which he argues will put a premium on "better systems, fewer mistakes (and) greater access."

"Healthcare is the only area of America's economy where the consumer and the provider have no idea what the goods and services they trade cost," Gingrich said. "The information age has left healthcare behind, and the consequences are tragic."

He may not be far off. Healthcare professionals who are far removed from the inside-the-Beltway politicking have

seen results by posting real prices --in other words, the exact amount a patient will have to pay for certain procedures.

In 1997, family doctor MacDonald posted the prices for a handful of common procedures on a Web site. He and his colleagues at SimpleCare, a national pay-as-you-go physician group for which he previously worked, saw results almost immediately. "Costs came down in every regard," MacDonald said. Diagnostic tests, CAT scans and MRIs all toppled in pricing. MRIs came down from $3,000 to about $600 and CAT scans dropped to about $300, he said.

SimpleCare also worked with several different laboratory companies to ensure that prices would drop even more. The pitch: "We told them that we would collect from the patient, then they would bill us at the end of the month."

By removing the billing and administrative costs associated with lab work, MacDonald said that costs for routine tests plummeted. So the price for a lipid profile, which ordinarily costs the hospital $47, dropped to $8, he said. But hospitals today still charge in the $100 to $120 range for the exact same test, he said.

Rep. Daniel Lipinski (D-Ill.) last July introduced legislation that would require hospitals to regularly report to HHS the amount they charge for 25 of the most common inpatient and outpatient procedures, as well as the 50 most frequently administered medications. HHS would then post this data on the Internet for public access. His bill has bipartisan support.

During the congressional hearing, Lipinski said that several states such as California, Florida, Georgia and his home base, Illinois, have passed similar legislation.

In testimony submitted to the committee, Gerard Anderson, director of the center for hospital finance and management at Johns Hopkins University, said that while he favors more transparency, pricing alone won't compel consumers to become better health shoppers.

Anderson said that for meaningful change, patients first need to know what services they will use. "Most patients do not understand what goods and services they may need and so they cannot comparative shop," he wrote. Secondly, he said that prices would have to reflect market forces, adding that list prices are established by hospital and physicians without any market constrains.

One way to do so is to base all rates on a single price standard, such as the Medicare payment rate.

Last December, Rep. Joe Barton (R-Texas), chairman of the House Energy and Commerce Committee, suffered a heart attack while ? ironically -- discussing Medicare with some of his colleagues. The popular Texan, who as committee chairman holds sway over much of the health legislation introduced in the House, was rushed to nearby George Washington Hospital in the district for treatment.

Now trimmer and healthier, Barton has used his firsthand brush with America's healthcare system, in part, as a guiding force to how he shapes his own health policy initiatives-price transparency included.

"When I was on the gurney in the emergency room, I wasn't really interested in what the cost was," he said last week during a congressional hearing on the topic. "I was very interested in the quality, though."

The hospital billed Blue Cross and Blue Shield more than $75,000 for the care, though Barton admits that no one -- not the doctors, nurses or even the top administrators -- could have given him that number had he asked.

And there's the rub: that very personal experience has at least played a part in shaping the congressman's view on healthcare costs, and whether or not they should be made public. From a dollars-and-cents aspect, Barton said he sees a move to clearer pricing as a strong first step to taming a healthcare system he says has run amok.

"I cannot think of another sector of our economy where consumers have less say," he said. "By limiting patients' access to comparative information, we restrict competition and cripple the ability of market forces to make healthcare more affordable."

But from the personal side, he is more succinct: "I don't personally know how much they actually paid, but I think it was worth every penny of it."

United States Department of Health & Human Services

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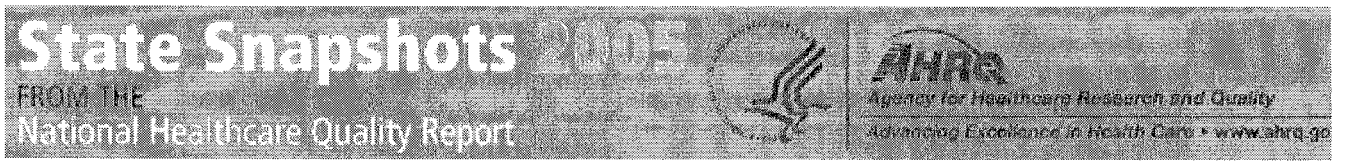

Snapshot Navigation
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View the National Map
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Welcome to the 2005 NHQR/NHDR *State Snapshots*

My State Compared to:
Use links in this box to find regional and national comparisons

The 2005 *State Snapshots* are dashboards of health care quality measures. The *Snapshots* include detailed, customized tables for each State. They should help State officials and their partners understand health care quality in their State, including strengths, weaknesses, and opportunities for improvements.

Specifically the 2005 *State Snapshots* provide:

Performance meters that show the State's performance on summary measures of the quality of types of care, settings of care, and overall quality of health care relative to the region or Nation on each summary measure. Also included are breakdowns of the measures that go into creating each of the performance meters.

State Ranking Tables that rank each State on 15 important measures of health care quality.

In-depth focus on diabetes that provides information on quality, disparities, costs, and lives associated with diabetes, as well as potential savings that may result from a focused quality improvement program.

A downloadable table that includes all available NHQR measures with State-level estimates.

Methods on how the summary measures were developed, scored, and presented within the performance meters, as well as how the focus on diabetes section was constructed.

To begin, select "View the National Map" from the left menu.

State Snapshots
FROM THE
National Healthcare Quality Report

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Focus on Diabetes
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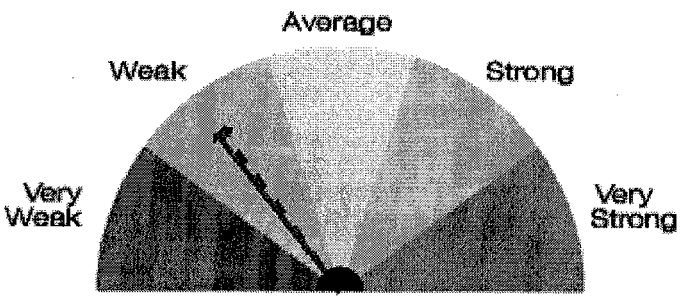
What Is Kentucky's Overall Health Care Quality Performance Compared to All States and How Has it Changed?

My State Compa
All States
East South Centr

The State's performance across all NHQR Quality Measures (up to 99) is shown below *compared to all States* in the **most recent data year (solid line)** and in a **preceding data year (dashed line).**



Performance Meter: All Measures

[D]

An arrow pointing to "very weak" means all or nearly all included measures for a State are worse than average within a given data year. Conversely, an arrow pointing to "very strong" indicates that all or nearly all available measures for a State are better than average within a given data year. The other categories scale from weak to strong performance and represent the State's balance of worse than average, average, and better than average measures. To examine all the measures behind this performance, click on the meter. For more information on how these measures are translated into a performance meter, select Methods, or to view additional information about this State, make a selection from the menu on the left.

FIRSTGOV

State Snapshots 2005
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Kentucky's Strongest and Weakest Measures

Strongest Measures are those in which the State performed better than the all-State average and are strongest among their measures relative to all reporting States. This State may be leading the way in quality in these measures.

Note: The *best* result for each measure can be either the highest or lowest value. The direction representing *best* is noted in parenthesis at the end of each measure description.

Kentucky's Strongest Measures

Infant mortality -- very low weight: Infant mortality per 1,000 live births, birthweight < 1,500 grams, by State, 2002 (best = lowest)

Nursing home short-stay residents -- with delerium: Post acute care: Percent of short-stay residents with delirium, by State, 2002 and 2004 (best = lowest)

Prenatal care: Percent of pregnant women receiving prenatal care in first trimester, by State, 1998 and 2002 (best = highest)

HIV deaths: HIV-infection deaths per 100,000 population, by State, 1999 and 2002 (best = lowest)

Home health care -- stabilization in bathing: Percent of stabilization in bathing for home health episodes, by State, 2002 and 2004 (best = highest)

Weakest Measures are those in which the State performed worse than the all-State average and are weakest among their measures relative to all reporting States. These measures highlight some of the opportunities for improvement.

Note: The *best* result for each measure can be either the highest or lowest value; the worst result is in the opposite direction. The direction representing *best* is noted in parenthesis at the end of each measure description.

Kentucky's Weakest Measures

Lung cancer deaths: Cancer deaths per 100,000 population per year for lung cancer, by State, 1999 and 2002 (best = lowest)

Avoidable hospitalizations -- heart failure: Admissions for congestive heart failure (excluding patients with cardiac procedures, obstetric and neonatal conditions, and transfers from other institutions) per 100,000 population, age 18 years and older, by State, 2001 and 2002 (best = lowest)

Avoidable hospitalizations -- pediatric gastroenteritis: Admissions for pediatric gastroenteritis (excluding obstetric and neonatal admissions and transfers from other institutions) per

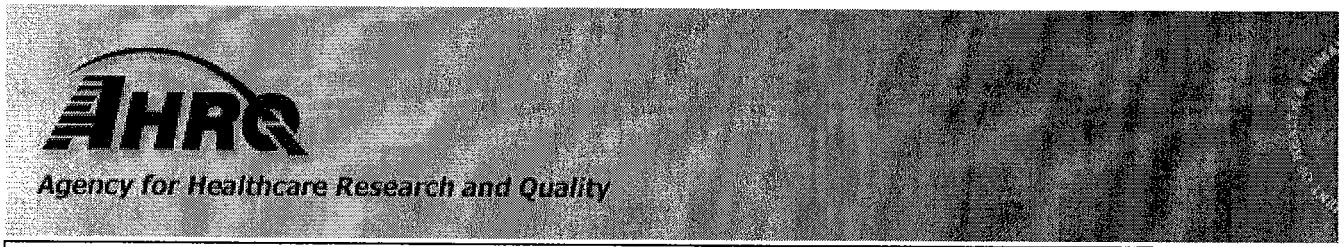
100,000 population, age less than 18 years, by State, 2001 and 2002 (best = lowest)

Nursing home residents -- with urinary tract infections: Chronic care: Percent of residents with a urinary tract infection, by State, 2003 and 2004 (best = lowest)

All cancer deaths: Cancer deaths per 100,000 population per year for all cancers, by State, 1999 and 2002 (best = lowest)

Colorectal cancer deaths: Cancer deaths per 100,000 population per year for colorectal cancer, by State, 1999 and 2002 (best = lowest)

States' specific performances on each of these measures are available in the All-State Data Table for All Measures.



AHRQuality Indicators

The Agency for Healthcare Research and Quality (AHRQ) Quality Indicators (QIs) are measures of health care quality that make use of readily available hospital inpatient administrative data.

The AHRQ QIs consist of four modules measuring various aspects of quality:

- **Prevention QIs** identify hospital admissions that evidence suggests could have been avoided, at least in part, through high-quality outpatient care. Download PQI Module.
- **Inpatient QIs** reflect quality of care inside hospitals including inpatient mortality for medical conditions and surgical procedures. Download IQI Module.
- **Patient Safety Indicators** also reflect quality of care inside hospitals, but focus on potentially avoidable complications and iatrogenic events. Download PSI Module.
- **Pediatric QIs** both reflect quality of care inside hospitals and identify potentially avoidable hospitalizations among children. Download PedQI Module.

Software and user guides for all four modules are available to assist users in applying the Quality Indicators to their own data.

News

Version 3.0 Released (Feb 2006)

February 2006 Newsletter

PQI Composite Measure Workgroup (Feb 2006)

RAND seeks participants in an evalu AHRQ QI Program (Nov 2005)

Featured Documents

AHRQ Summary Statement on Corr Hospital Public Reporting (Dec 200

AHRQ QI Users Meeting (Sept 26-27 Presentations

AHRQuality Indicators

Prevention Quality Indicators Overview

The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care-sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

The PQIs are a software tool distributed free by AHRQ. The software can be used to help hospitals identify quality of care events that might need further study. The PQI software programs can be applied to any hospital inpatient administrative data. These data are readily available and relatively inexpensive to use.

Even though these indicators are based on hospital inpatient data, they provide insight into the community health care system or services outside the hospital setting. Patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored or if they do not receive the patient education needed for appropriate self-management.

Patients may be hospitalized for asthma if primary care providers fail to adhere to practice guidelines or to prescribe appropriate treatments. Patients with appendicitis who do not have ready access to surgical evaluation may experience delays in receiving needed care, which can result in a life-threatening condition—perforated appendicitis.

The Prevention Quality Indicators are part of a set of Agency Healthcare Research and Quality (AHRQ) Quality Indicators (QIs) developed by investigators at Stanford University and the University of California under a contract with AHRQ.

The AHRQ QIs expand the original Healthcare Cost and Utilization Project (HCUP) QIs. The PQIs were released in November 2001. The Inpatient Quality Indicators, the second set, were released in May 2002. The third set, the Patient Safety Indicators, were released in March 2003.

PQI Facts

Prevention Quality Indicators:

- Can be used as a "screening tool" to help flag potential health

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care quality problem areas that need further investigation.
- Can provide a quick check on primary care access or outpatient services in a community by using patient data found in a typical hospital discharge abstract.
- Can help public health agencies, State data organizations, health care systems, and others interested in improving health care quality in their communities.
- Are population based and adjusted for age and sex.
- Are publicly available without cost.
- Are available for download.

The Prevention Quality Indicators represent hospital admission rates for the following 14 ambulatory care sensitive conditions:

- Diabetes, short-term complications (PQI 1)
- Perforated appendicitis (PQI 2)
- Diabetes, long-term complications (PQI 3)
- Chronic obstructive pulmonary disease (PQI 5)
- Hypertension (PQI 7)
- Congestive heart failure (PQI 8)
- Low birth weight (PQI 9)
- Dehydration (PQI 10)
- Bacterial pneumonia (PQI 11)
- Urinary infections (PQI 12)
- Angina without procedure (PQI 13)
- Uncontrolled diabetes (PQI 14)
- Adult asthma (PQI 15)
- Lower extremity amputations among patients with diabetes (PQI 16)

With high-quality, community-based primary care, hospitalization for these illnesses often can be avoided.

Although other factors outside the direct control of the health care system, such as poor environmental conditions or lack of patient adherence to treatment recommendations, can result in hospitalization, the PQIs provide a good starting point for assessing quality of health services in the community. Because the PQIs are calculated using readily available hospital administrative data, they are an easy-to-use and inexpensive screening tool. They can be used to provide a window into the community—to identify unmet community heath care needs, to monitor how well complications from a number of common conditions are being avoided in the outpatient setting, and to compare performance of local health care systems across communities.

Internet Citation:

Prevention Quality Indicators Overview. AHRQ Quality Indicators. July 2004.

Agency for Healthcare Research and Quality, Rockville, MD.
http://www.qualityindicators.ahrq.gov/pqi_overview.htm

AHRQ Quality Indicators

Inpatient Quality Indicators Overview

The Inpatient Quality Indicators (IQIs) are a set of measures that provide a perspective on hospital quality of care using hospital administrative data. These indicators reflect quality of care inside hospitals and include inpatient mortality for certain procedures and medical conditions; utilization of procedures for which there are questions of overuse, underuse, and misuse; and volume of procedures for which there is some evidence that a higher volume of procedures is associated with lower mortality.

The IQIs are a software tool distributed free by the Agency for Healthcare Research and Quality (AHRQ). The software can be used to help hospitals identify potential problem areas that might need further study and which can provide an indirect measure of inhospital quality of care. The IQI software programs can be applied to any hospital inpatient administrative data. These data are readily available and relatively inexpensive to use.

The IQIs are the second in the set of AHRQ Quality Indicators (QIs) developed by investigators at Stanford University and the University of California, under a contract with AHRQ.

The AHRQ QIs expanded the original Quality Healthcare Cost and Utilization Project (HCUP) QIs. The Prevention Quality Indicators, the first set of AHRQ QIs, were released in November 2001. The IQIs were released of in May 2002. The third set, the Patient Safety Indicators, were released in March 2003. In February 2006, the fourth QI module, the Pediatric Quality Indicators, was added while the pediatric population was removed from the other modules.

IQI Facts

Inpatient Quality Indicators:

- Can be used to help hospitals identify potential problem areas that might need further study.
- Provide the opportunity to assess quality of care inside the hospital using administrative data found in the typical discharge record.
- Include 15 mortality indicators for conditions or procedures for which mortality can vary from hospital to hospital.
- Include 11 utilization indicators for procedures for which utilization varies across hospitals or geographic areas.

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- Include 6 volume indicators for procedures for which outcomes may be related to the volume of those procedures performed.
- Are publicly available without cost.
- Are available for download.

The IQIs include the following 32 measures:

1. Mortality Rates for Medical Conditions (7 Indicators)
    - Acute myocardial infarction (AMI) (IQI 15)
    - AMI, Without Transfer Cases (IQI 32)
    - Congestive heart failure (IQI 16)
    - Stroke (IQI 17)
    - Gastrointestinal hemorrhage (IQI 18)
    - Hip fracture (IQI 19)
    - Pneumonia (IQI 20)
2. Mortality Rates for Surgical Procedures (8 Indicators)
    - Esophageal resection (IQI 8)
    - Pancreatic resection (IQI 9)
    - Abdominal aortic aneurysm repair (IQI 11)
    - Coronary artery bypass graft (IQI 12)
    - Percutaneous transluminal coronary angioplasty (IQI 30)
    - Carotid endarterectomy (IQI 31)
    - Craniotomy (IQI 13)
    - Hip replacement (IQI 14)
3. Hospital-level Procedure Utilization Rates (7 Indicators)
    - Cesarean section delivery (IQI 21)
    - Primary Cesarean delivery (IQI 33)
    - Vaginal Birth After Cesarean (VBAC), Uncomplicated (IQI 22)
    - VBAC, All (IQI 34)
    - Laparoscopic cholecystectomy (IQI 23)
    - Incidental appendectomy in the elderly (IQI 24)
    - Bi-lateral cardiac catheterization (IQI 25)
4. Area-level Utilization Rates (4 Indicators)
    - Coronary artery bypass graft (IQI 26)
    - Percutaneous transluminal coronary angioplasty (IQI 27)
    - Hysterectomy (IQI 28)
    - Laminectomy or spinal fusion (IQI 29)
5. Volume of Procedures (6 Indicators)
    - Esophageal resection (IQI 1)
    - Pancreatic resection (IQI 2)
    - Abdominal aortic aneurysm repair (IQI 4)
    - Coronary artery bypass graft (IQI 5)
    - Percutaneous transluminal coronary angioplasty (IQI 6)
    - Carotid endarterectomy (IQI 7)

Internet Citation:

Inpatient Quality Indicators Overview. AHRQ Quality Indicators. February 2006. Agency for Healthcare Research and Quality, Rockville, MD. http://www.qualityindicators.ahrq.gov/iqi_overview.htm

Pediatric Quality Indicators Overview

The Pediatric Quality Indicators (PDIs) are a set of measures that can be used with hospital inpatient discharge data to provide a perspective on the quality of pediatric healthcare. Specifically, PDIs screen for problems that pediatric patients experience as a result of exposure to the healthcare system and that may be amenable to prevention by changes at the system or provider level.

Development of quality indicators for the pediatric population involves many of the same challenges associated with the development of quality indicators for the adult population. These challenges include the need to carefully define indicators using administrative data, establish validity and reliability, detect bias and design appropriate risk adjustment, and overcome challenges of implementation and use. However, the special population of children invokes additional, special challenges. Four factors—differential epidemiology of child healthcare relative to adult healthcare, dependency, demographics, and development—can pervade all aspects of children's healthcare; simply applying adult indicators to younger age ranges is insufficient

This PDIs focus on potentially preventable complications and iatrogenic events for pediatric patients treated in hospitals, and on preventable hospitalizations among pediatric patients.

The Pediatric Quality Indicators are a part of Agency Healthcare Research and Quality (AHRQ) Quality Indicators (QIs) developed by investigators at Stanford University and the University of California under a contract with AHRQ.

The PDIs are a software tool distributed free by AHRQ. The software can be used to help hospitals identify potential adverse events that might need further study. The PDI software programs can be applied to any hospital inpatient administrative data. These data are readily available and relatively inexpensive to use.

The PDIs are the fourth in a four-part set of AHRQ Quality Indicators (QIs).

PDI facts

Pediatric Quality Indicators:

- Apply to the special characteristics of the pediatric population.

- Screen for problems that pediatric patients experience as a result of exposure to the healthcare system and that may be amenable to prevention by changes at the provider level or area level.
- Help to evaluate preventive care for children in an outpatient setting, and most children are rarely hospitalized.
- Are free and publicly available.
- Are available for download.

The PDIs provide a perspective on patient safety events using hospital administrative data, which are readily available and relatively inexpensive to use.

The PDIs include 13 Provider-level and 5 Area-level Indicators.

Provider-level Pediatric Quality Indicators (13 Indicators)

- Accidental Puncture or Laceration (PDI 1)
- Decubitus Ulcer (PSI 2)
- Foreign Body Left During Procedure (PDI 3)
- Iatrogenic Pneumothorax in Neonates at Risk (PDI 4)
- Iatrogenic Pneumothorax in Non-neonates (PDI 5)
- Pediatric Heart Surgery Mortality (PDI 6)
- Pediatric Heart Surgery Volume (PDI 7)
- Postoperative Hemorrhage or Hematoma (PDI 8)
- Postoperative Respiratory Failure (PDI 9)
- Postoperative Sepsis Wound Dehiscence (PDI 10)
- Postoperative Wound Dehiscence (PDI 11)
- Selected Infections Due to Medical Care (PDI 12)
- Transfusion Reaction (PDI 13)

Area-level Pediatric Quality Indicators (5 Indicators)

- Asthma Admission Rate (PDI 14)
- Diabetes Short-Term Complication Rate (PDI 15)
- Gastroenteritis Admission Rate (PDI 16)
- Perforated Appendix Admission Rate (PDI 17)
- Urinary Tract Infection Admission Rate (PDI 18)

Internet Citation:

Pediatric Quality Indicators Overview. AHRQ Quality Indicators. February 2006. Agency for Healthcare Research and Quality, Rockville, MD. http://www.qualityindicators.ahrq.gov/pdi_overview.htm

AHRQ Quality Indicators

Patient Safety Indicators Overview

The Agency for Healthcare Research and Quality (AHRQ) Quality Indicators (QIs) measure health care quality by using readily available hospital inpatient administrative data. The Patient Safety Indicators (PSIs) are a tool to help health system leaders identify potential adverse events occurring during hospitalization.

The PSIs are a set of indicators providing information on potential inhospital complications and adverse events following surgeries, procedures, and childbirth. The PSIs were developed after a comprehensive literature review, analysis of ICD-9-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.

The PSIs are a software tool distributed free by AHRQ. The software can be used to help hospitals identify potential adverse events that might need further study. The PSI software programs can be applied to any hospital inpatient administrative data. These data are readily available and relatively inexpensive to use.

The PSIs form the third of a set of AHRQ QIs developed by investigators at Stanford University and the University of California, under a contract with AHRQ.

The AHRQ QIs expanded the original Healthcare Cost and Utilization Project (HCUP) QIs. The Prevention Quality Indicators, the first set of AHRQ QIs, were released in November 2001. The second set, the Inpatient Quality Indicators, were released in May 2002. The PSIs were released in March 2003. In February 2006, the fourth QI module, the Pediatric Quality Indicators, was added while the pediatric population was removed from the other modules.

AHRQ is making the Patient Safety Indicators software available without charge to hospitals and other users as SAS® and SPSS® programs with software documentation and a user guide that provides a synopsis of the evidence taken from the "Measures of Patient Safety Based on Hospital Administrative Data."

PSI Facts

Patient Safety Indicators:

- Can be used to help hospitals identify potential adverse events

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that might need further study.

- Provide the opportunity to assess the incidence of adverse events and inhospital complications using administrative data found in the typical discharge record.
- Include 20 indicators for complications occurring inhospital that may represent patient safety events.
- Six indicators also have area level analogs designed to detect patient safety events on a regional level.
- Are free and publicly available.
- Are available for download.

The PSIs provide a perspective on patient safety events using hospital administrative data, which are readily available and relatively inexpensive to use, and include the following 27 measures:

1. Hospital-level Patient Safety Indicators (20 Indicators)
    - Complications of anesthesia (PSI 1)
    - Death in low mortality DRGs (PSI 2)
    - Decubitus ulcer (PSI 3)
    - Failure to rescue (PSI 4)
    - Foreign body left in during procedure (PSI 5)
    - Iatrogenic pneumothorax (PSI 6)
    - Selected infections due to medical care (PSI 7)
    - Postoperative hip fracture (PSI 8)
    - Postoperative hemorrhage or hematoma (PSI 9)
    - Postoperative physiologic and metabolic derangements (PSI 10)
    - Postoperative respiratory failure (PSI 11)
    - Postoperative pulmonary embolism or deep vein thrombosis (PSI 12)
    - Postoperative sepsis (PSI 13)
    - Postoperative wound dehiscence in abdominopelvic surgical patients (PSI 14)
    - Accidental puncture and laceration (PSI 15)
    - Transfusion reaction (PSI 16)
    - Birth trauma -- injury to neonate (PSI 17)
    - Obstetric trauma -- vaginal delivery with instrument (PSI 18)
    - Obstetric trauma -- vaginal delivery without instrument (PSI 19)
    - Obstetric trauma -- cesarean delivery (PSI 20)

2. Area-level Patient Safety Indicators (7 Indicators)
    - Foreign body left in during procedure (PSI 21)
    - Iatrogenic pneumothorax (PSI 22)
    - Selected infections due to medical care (PSI 23)
    - Postoperative wound dehiscence in abdominopelvic surgical patients (PSI 24)
    - Accidental puncture and laceration (PSI 25)

- Transfusion reaction (PSI 26)
- Post-operative hemorrhage or hematoma (PSI 27)

Internet Citation:

Patient Safety Indicators Overview. AHRQ Quality Indicators. February 2006. Agency for Healthcare Research and Quality, Rockville, MD. http://www.qualityindicators.ahrq.gov/psi_overview.htm

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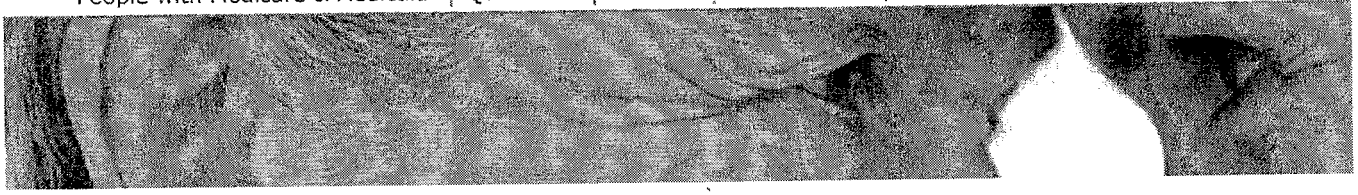

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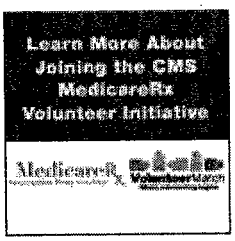

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MDS Quality Indicator Report

Select a Quality Indicator domain or group from the selection box below.

Domain/Quality Indicator	Subject Areas
Accidents	■ Incidence of new fractures ■ Prevalence of Falls
Behavior/Emotional Patterns	■ Prevalence of Behavioral Symptoms Affecting Others - All ■ Prevalence of Behavioral Symptoms Affecting Others - High ■ Prevalence of Behavioral Symptoms Affecting Others - Low ■ Prevalence of Symptoms of Depression ■ Prevalence of Symptoms of Depression with No Antidepressant Therapy
Clinical Management	■ Use of 9 or More Different Medications
Cognitive Patterns	■ Incidence of Cognitive Impairment
Elimination/Incontinence	■ Prevalence of Bladder or Bowel Incontinence - All ■ Prevalence of Bladder or Bowel Incontinence - High ■ Prevalence of Bladder or Bowel Incontinence - Low ■ Prevalence of Occasional or Frequent Bladder or Bowel Incontinence Without a Toileting Plan ■ Prevalence of Indwelling Catheters ■ Prevalence of Fecal Impaction
Infection Control	■ Prevalence of Urinary Tract Infections
Nutrition/Eating	■ Prevalence of Weight Loss ■ Prevalence of Tube Feeding ■ Prevalence of Dehydration
Physical Functioning	■ Prevalence of Bedfast Residents ■ Incidence of Decline in Late-loss ADLs ■ Incidence of Decline in ROM
Psychotropic Drug Use	■ Prevalence of Antipsychotic Use in the Absence of Psychotic or Related Conditions - All ■ Prevalence of Antipsychotic Use in the Absence of Psychotic or Related Conditions - High ■ Prevalence of Antipsychotic Use in the Absence of Psychotic or Related Conditions - Low ■ Prevalence of Any Antianxiety/Hypnotic Use ■ Prevalence of Hypnotic Use More Than Two Times in the Last Week
Quality of Life	■ Prevalence of Daily Physical Restraints ■ Prevalence of Little or No Activity
	■ Prevalence of Stage 1-4 Pressure Ulcers - All

Skin Care	■ Prevalence of Stage 1-4 Pressure Ulcers - High ■ Prevalence of Stage 1-4 Pressure Ulcers - Low

Select different report | Select different date

MDS Quality Indicator Report for Accidents- January/March 2005

QI01: Incidence of new fractures
Residents who have a hip fracture or other fractures that are new since the last assessment.

QI02: Prevalence of Falls
Residents who have been coded with a fall within the time frame of the most recent assessment (past 30 days).

Figures indicate percentage across state of residents exceeding Quality Indicator trigger. To view a description of the report table contents, click here .

State	QI01	QI02
National	1.5%	13.0%
Alabama	1.4%	10.9%
Alaska	1.6%	16.0%
Arizona	1.9%	13.3%
Arkansas	1.4%	11.5%
California	0.9%	7.2%
Colorado	1.8%	17.0%
Connecticut	1.4%	12.1%
Delaware	1.6%	15.2%
Florida	1.6%	12.1%
Georgia	1.5%	12.4%
Hawaii	0.9%	7.7%
Idaho	1.5%	14.7%
Illinois	1.4%	13.0%
Indiana	1.6%	15.8%
Iowa	1.7%	15.5%
Kansas	1.8%	15.6%
Kentucky	1.7%	15.1%
Louisiana	1.2%	12.0%
Maine	1.4%	17.1%
Maryland	1.3%	12.7%
Massachusetts	1.4%	12.8%
Michigan	1.5%	14.6%

Minnesota	1.9%	16.6%
Mississippi	1.3%	10.3%
Missouri	1.5%	15.0%
Montana	1.6%	18.4%
Nebraska	1.5%	17.6%
Nevada	1.3%	12.0%
New Hampshire	1.5%	15.8%
New Jersey	1.3%	11.1%
New Mexico	1.3%	15.7%
New York	1.3%	10.6%
North Carolina	1.6%	12.3%
North Dakota	1.7%	17.8%
Ohio	1.4%	13.7%
Oklahoma	1.8%	13.3%
Oregon	1.4%	15.0%
Pennsylvania	1.6%	13.7%
Puerto Rico	0.0%	16.7%
Rhode Island	1.4%	15.1%
South Carolina	1.4%	12.6%
South Dakota	1.7%	18.5%
Tennessee	1.5%	12.4%
Texas	1.4%	10.9%
Utah	1.4%	18.0%
Vermont	1.3%	18.4%
Virgin Islands	0.0%	1.3%
Virginia	1.7%	14.3%
Washington	1.8%	15.7%
Washington, D.C.	0.6%	10.2%
West Virginia	1.7%	13.2%
Wisconsin	1.4%	14.8%
Wyoming	1.8%	16.4%

Source: MDS National Quality Indicator System.

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Tuesday, March 28

Contact Information

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Email contact

NQF Members

Disclaimer

About the National Quality Forum

The National Quality Forum (NQF) is a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting. A shared sense of urgency about the impact of health care quality on patient outcomes, workforce productivity, and health care costs prompted leaders in the public and private sectors to create the NQF as a mechanism to bring about national change.

Established as a public-private partnership, the NQF has broad participation from all parts of the health care system, including national, state, regional, and local groups representing consumers, public and private purchasers, employers, health care professionals, provider organizations, health plans, accrediting bodies, labor unions, supporting industries, and organizations involved in health care research or quality improvement. Together, the organizational members of the NQF will work to promote a common approach to measuring health care quality and fostering system-wide capacity for quality improvement.

History of the Quality Forum

In a report issued in 1998, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry proposed creation of the Forum as part of an integrated national quality improvement agenda. Leaders from consumer, purchaser, provider, health plan, and health service research organizations met as the Quality Forum Planning Committee throughout 1998 and early 1999 to define the mission, structure, and financing of the Forum. The Forum was incorporated as a new organization in May 1999. (top)

Why the Forum Is Important

The American health care system offers millions of patients access to health care provided by highly skilled, committed professionals and first-rate health care institutions, as well as the advantages of the latest innovations in clinical research, technology, and treatment. At the same time, the system is marked by serious and pervasive deficiencies in quality. Quality problems affect all patients, regardless of age, gender, financial resources, or race. In addition, quality problems cut across the delivery system, and are not the result of any single financing or payment arrangement. Quality deficiencies result in increased mortality and morbidity and in failure to alleviate

conditions that cause pain and disability, leading to a lower quality of life, a less productive workforce, and billions of dollars in unnecessary costs.

Challenges in Health Care Quality

Tremendous geographic variation in the use of clinical procedures suggests the scope of quality deficiencies. Relying on a growing body of research, quality experts have identified three other principal indicators of quality problems:

Error Rates. Inadequate diagnosis and treatment cause unnecessary mortality and morbidity, increasing the burden, complications, and cost of treatment.

An estimated 180,000 deaths are caused each year by medical error.

An estimated 30 percent of acute care patients and 20 percent of chronically ill patients receive care that is contraindicated.

Overtreatment. Millions of patients receive treatments each year that they do not need, leading to complications, reduced productivity, and significantly higher costs.

Experts estimate that approximately 20 to 30 percent of health care treatments are unnecessary.

Overuse has been well documented for numerous types of invasive surgery and tests; an estimated 16 percent of hysterectomies and 17 percent of coronary angiograms performed each year are unnecessary.

Undertreatment. Studies consistently show the failure to provide effective treatments, ranging from life-saving interventions that can reduce mortality, such as taking aspirin to lower the risk of heart attack, to vaccinations that prevent serious illness in the elderly and children.

Only an estimated 50 percent of patients receive recommended preventive care.

Among individuals suffering from depression, 59 percent are not treated and 19 percent receive ineffective treatment, leading to an estimated $12 billion annual loss in employee productivity. (top)

How the Quality Forum Works

The NQF is governed by a 23-member Board of Directors representing health care consumers, purchasers, providers, health plans, and experts in health services research. The Board includes representatives from two federal agencies, the Center For Medicaid and Medicare Services and the Agency for Health Care Research and Quality. Four members of the Board have been elected by members of the Forum, voting through Member Councils.

The Forum has also convened a standing panel of leading experts in

quality improvement and measurement to identify the principles and priorities that will guide a national measurement and reporting strategy. Building on this effort and the work of public and private quality improvement organizations, the Forum will endorse quality measures for national use. The Forum will also promote the use of quality information, and develop a research agenda to advance quality improvement. (top)

Member Councils

Member organizations of the NQF have the opportunity to take part in a national dialogue about how to measure health care quality and report the findings to consumers, purchasers, providers, and policymakers. Members will vote on Forum leadership and participate in the Forum through one of four Member Councils: the Consumer Council, Purchaser Council, Provider and Health Plan Council, and Research and Quality Improvement Council.

Consumer Council
The Forum will promote development and dissemination of quality information to enhance consumer choice and to foster public understanding and use of quality information. Members of the Consumer Council will be national, state, regional, and local consumer organizations as well as labor unions. Through the Council, diverse consumer organizations can develop a shared vision of consumer needs for quality information, and how the Forum can best meet those needs.

Purchaser Council
In their role as purchasers of health care and as employers, private corporations and government agencies have an enormous stake in improving quality, reducing the cost of illness, and enhancing the health and productivity of the workforce. The Purchaser Council will provide a venue for public and private purchasers to build demand and capacity for quality improvement. Members of this Council will include public purchasers (federal, state, and local), regional purchasing coalitions, corporations, and business groups.

Health Professional, Provider, and Health Plan Council
The NQF will promote valid, comparative data needed to improve health care quality. Participants in the Provider and Health Plan Council will include physician and nurse organizations, health plans, health systems, hospitals, ambulatory care facilities, home care agencies, long-term care and other residential facilities, and groups of health care practitioners. By promoting a shared agenda on quality among providers and collaboration with purchasers, the Forum could significantly advance quality improvement and reduce the cost and burden of reporting on duplicative measures.

Research and Quality Improvement Council
The Forum will build on advances made by quality improvement organizations and experts to promote use of quality measures by purchasers, consumers, providers, and policymakers. Members of this Council will be organizations that conduct research, education, or initiatives to improve health care quality, measurement, and reporting. They will include accrediting bodies, professional schools, policy or quality centers, federal, state, and local government agencies, and supporting industries such as medical suppliers. (top)

In addition to the four member councils, the NQF has convened a Healthcare Technology Section which is a "home" for knowledgeable NQF Member representatives from information technology companies and IT membership organizations, medical device manufacturers, pharmaceutical companies, hospital equipment and durable medical equipment suppliers, and other technology-related vendors. The NQF's Healthcare Technology Section will provide a forum for discussion and networking by technology-related organizations; address issues of interest to technology-related companies and facilitate the integration of technology in healthcare quality improvement activities; and assume an active role in NQF membership. (top)

How the NQF Is Funded

One key source of funding for the NQF is membership dues. In addition to membership dues, the Forum receives significant public and private funding, including foundation and corporate grants. The Forum received a founding grant of $2.5 million from The Robert Wood Johnson Foundation. Download a list of other founding funders. (top)

Board of Directors

Joel T. Allison, MS, is President and Chief Executive Officer of Baylor Health Care System, Dallas, TX.

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Janet M. Corrigan, PhD, MBA, is President and CEO of the National Quality Forum and the National Committee for Quality Health Care, Washington, DC.

Nancy-Ann Min DeParle, Esq., is Senior Advisor for JPMorgan Partners, Washington, DC, and is Adjunct Professor of Health Care Systems, The Wharton School.

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for Quality Healthcare, Washington, DC.

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Jeffrey B. Rich, MD is Chair of the Virginia Cardiac Surgery Quality Initiative, Norfolk, VA.

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Gerald M. Shea is Assistant to the President for Government Affairs at AFL-CIO, Washington, DC.

Janet Sullivan, MD, is Chief Medical Officer for HealthSource/Hudson Health Plan, Tarrytown, NY.

James W. Varnum is President of Dartmouth-Hitchcock Alliance, Lebanon, NH.

Gail L. Warden, Chairman Emeritus of the National Quality Forum, is President Emeritus for Henry Ford Health System, Detroit, MI.

Andrew Webber is President and Chief Executive Officer, National Business Coalition on Health, Washington, DC.

Marina L. Weiss is Senior Vice President for Public Policy and Government Affairs at the March of Dimes, Washington, DC.

Liaison Members

Clyde Behney is the Deputy Executive Officer at the Institute of Medicine, National Academy of Sciences, Washington, DC

David J. Brailer, MD, PhD, is National Coordinator for Health Information Technology, Department of Health and Human Services,

Washington, DC.

Nancy H. Nielsen, MD, PhD, Physician Consortium for Performance Improvement, AMA, Chicago, Illinois.

Margaret E. O'Kane is President of the National Committee for Quality Assurance in Washington, DC.

Dennis S. O'Leary, MD, is President of the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, Illinois.

Elias A. Zerhouni, MD, is Director of the National Institutes of Health, Bethesda, Maryland.

(top)

Strategic Advisory Council

Donald M. Berwick, MD, (chair) is President and Chief Executive Officer of the Institute for Healthcare Improvement Boston, Massachusetts.

Molly J. Coye, MD, MPH is the PriceWaterhouseCoopers Fellow at the Institute for the Future, Menlo Park, California .

Nancy-Ann Min DeParle, Esq. is a Senior Advisor at JPMorgan Partners, Washington, DC and is Adjunct Professor of Health Care Systems, The Wharton School.

Robert S. Galvin, MD is Director of Health Care at General Electric Company Fairfield, Connecticut.

Judith H. Hibbard, DrPh is a Professor of Health Policy Department of Planning, Public Policy and Management at the University of Oregon, Eugene, Oregon.

Risa Lavizzo-Mourey, MD, MPH is the President of the Robert Wood Johnson Foundation, Princeton, New Jersey.

Brent C. James, MD is the Vice President of Med. Res. & Cont. Med. Ed. and Exec Dir, at the Institute for Health Care Delivery Research Intermountain Health Care, Salt Lake City, Utah.

Sheila Leatherman, School of Public Health and Program on Health Outcomes, University of North Carolina, Durham, North Carolina

Elizabeth A. McGlynn, PhD is the Director of the Center for Research on Quality in Health Care RAND, Santa Monica, California .

Arnold Milstein, MD, MPH, is the Medical Director at Pacific Business Group on Health and William M. Mercer & Company, San Francisco, California.

Helen L. Smits, MD is a Visiting Professor at the Graduate School of

Public Service, New York University New York, New York.

(top)

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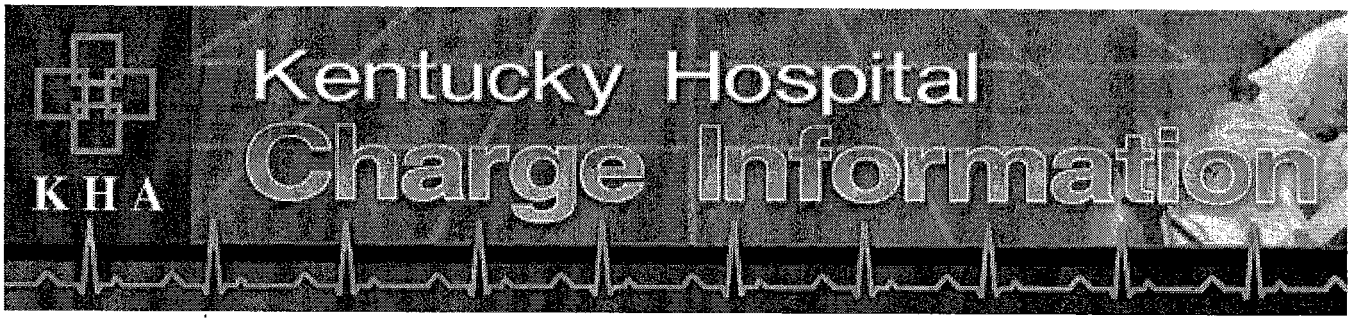


Who is Kentucky Hospital Association (KHA)?

Founded more than 70 years ago, the Kentucky Hospital Association is a partnership of people and organizations dedicated to improving health care delivery throughout the Commonwealth. The Association facilities collaborative efforts among Kentucky hospitals, all of which are members of KHA, and is the source for strategic information about the constantly changing health care environment. The mission of the Kentucky Hospital Association is to provide representation and member services that assist hospitals to fulfill their mission in serving the health care needs of the public.

About This Report

Through publication of this report, Kentucky's hospital continue their commitment to helping the public better understand the health care delivery system and cost of health care services.

The Kentucky Hospital Association collects billing data from all Kentucky acute care hospitals for all patients who were admitted for inpatient care. Hospitals report data on a quarterly basis. This report covers inpatient discharges at Kentucky's acute care hospitals for the most recent 12 month period where quarterly data has been finalized.

The information in this report is hospital-specific and includes for each RDRG (Refined Diagnosis Related Group) the number of cases each hospital treated for the DRG, the median length of stay and median charges by four severity of illness levels, and the median age of patients. Information is provided on the top 100 RDRGs that account for more than 86% of all admissions to Kentucky acute care hospitals. KHA intends to expand the list of DRGs included in this report to additional conditions if patient volume is large enough to support statistically reliable data.

Why Provide Information on DRGs?

The data provided to KHA by Kentucky hospitals is grouped into illness categories, called Diagnosis Related Groups, or DRGs. DRGs group similar patients requiring similar hospital resources to take care of them, and similar anticipated lengths of stay. Each patient admitted to the hospital gets assigned one DRG for that visit. It is based on a number of factors: the main diagnosis for the admission, along with other conditions noted, procedures performed, and age of patient. Other conditions that can influence the DRG assigned are complications and co-morbidities that cause the hospital stay to be longer in many persons. A DRG is then broken down into severity levels and assigned an RDRG. Providing information about RDRGs can give you an idea about the types of cases that particular hospitals are seeing.

Hospital Charges

This report includes median hospital charge information for discharges falling within a given severity level for a diagnostic condition (RDRG). The policy and setting of charges is determined by individual hospital. While charges are what the hospital reports on the billing form, they may not accurately represent the amount a hospital receives in payment for the services it delivers. However, hospital charges are used almost universally by those attempting to assess the costs of health care. ***Hospital charge data does not include separate physician charges.***

The charges listed are averages for items and services provided by hospitals, based on the number of patients and total charges for that illness. Figures include charges for the hospital room, meals, 24 hour Nursing care, 24 hour Pharmacy, Oxygen and IV Therapy, Physical and Respiratory therapy, Laboratory tests, state-of-the-art equipment (x-ray, MRI, CT), pharmaceuticals and patient supplies such as gowns, walkers and wheelchairs.

The median value was used in order to eliminate extremely low or high charges. Without these extreme values, the average charges and the typical range of charges are more representative of the charges that most patients would experience. A hospital's charges for the 10^{th} percentile and 90^{th} percentile reflect a statistical standard range. About 80% of the time, the hospital's total listed charge will be between the 10^{th} and 90^{th} percentiles. This helps to tell you what is likely to happen within a given hospital. Because these figures are averages, they may be different from what you are billed. The numbers do not measure quality of care.

Why Charges May Vary

Charges vary because no two patients, conditions, reactions to medications or treatment, or time of recovery are identical.

Individual physician judgment based on patient needs influences treatment decisions. Some DRGs have little variation of charges within the minor severity level because physicians agree on standard treatment procedures. Other DRGs can have a significant range of charges, even within the minor severity level, because the DRG includes a wide variety of illnesses and treatment among these illnesses is not standardized. Charges may be higher at hospitals located in areas of the state where wage levels and cost of living is higher. Hospitals affiliated with medical schools and those which incur additional costs associated with training medical and allied health students may also have higher charges.

Volume of Cases

For each hospital, the total number of cases for each condition (RDRG) is reported. This can give a patient an idea of the experience each facility has in treating such patients.

The number of cases represents separate hospital admissions, not individual patients. A patient readmitted several times would be included each time in the number of cases.

Hospitals are not listed on a report if they had fewer than 20 cases treated for that condition within the 12 month period covered by the data. Such low volume cannot be considered meaningful.

Length of Stay

Length of stay in a hospital can vary because of many factors, such as older patients requiring more services, hospitals treating patients who are more severely ill than the average patient or who have more complications and/or multiple conditions requiring treatment during their hospitalization. Length of stay can be shorter for hospitals where additional resources such as

nursing home or home health services are readily available in the community to provide any necessary follow up care.

How to Use This Report

This report can be used as a tool. It should not be used to generalize about the overall quality of care at a hospital. Consumers should talk with your physician and ask the following questions:

Ask which DRG category and severity level might be comparable to your condition

Ask how your illness and health status might affect procedures performed, length of stay, and the cost of your care

Ask your insurance company what is covered under your plan and what you will be expected to pay out of pocket for the proposed medical care

Ask what other additional charges you can expect to receive from physicians who may provide services during your hospitalization, such as pathology, radiology, or other consultations.

Refined DRG Report
Kentucky Acute Care Hospitals - Inpatient Data
DRG : '209' Maj Joint & Limb Reattach Proc /of Lower Extremity
Severity Level: '0'
Year: '2004'

Hospital	Discharges	Median Charges	10th Percentile	90th Percentile	Median Length of Stay	Median Age
Statewide	5545	$25,649.68	$16,974.60	$37,979.89	3	65
BAPTIST HOSPITAL EAST	1027	$19,476.80	$15,024.32	$24,383.27	3	65
JEWISH HOSPITAL - LOUISVILLE	366	$35,170.14	$28,784.92	$42,420.19	3	62
ST JOSEPH HOSPITAL	299	$24,111.09	$21,359.52	$31,315.47	3	64
SAMARITAN HOSPITAL-LEXINGTON	278	$32,176.21	$27,845.08	$40,638.13	4	68
SAINT JOSEPH HOSPITAL - EAST	274	$23,009.31	$19,706.63	$30,644.60	4	61
NORTON HOSPITAL - LOUISVILLE	244	$37,159.75	$28,047.92	$48,615.33	3	64
ST ELIZABETH HOSPITAL - SOUTH	237	$30,827.76	$26,649.59	$35,805.97	3	67
CARITAS MEDICAL CENTER	196	$25,154.93	$19,438.56	$36,700.68	3	66
KING'S DAUGHTER'S MEDICAL CENTER	184	$20,227.76	$12,480.53	$25,378.79	3	67
OWENSBORO MEDICAL HEALTH SYSTEM	182	$27,277.91	$22,000.78	$31,367.46	3	64
THE MEDICAL CENTER/BOWLING GREEN	165	$26,932.86	$19,547.99	$31,828.67	4	65
LOURDES HOSPITAL	127	$27,277.22	$23,988.41	$32,695.14	4	67
WESTERN BAPTIST HOSPITAL	113	$33,212.56	$25,676.45	$39,736.50	4	68
CENTRAL BAPTIST HOSPITAL	110	$29,138.85	$18,422.88	$40,591.20	4	61
NORTON SUBURBAN HOSPITAL	102	$37,136.00	$25,509.48	$46,878.20	4	66
NORTON AUDUBON HOSPITAL	101	$38,241.00	$32,721.75	$44,338.00	4	66
T J SAMSON COMMUNITY HOSPITAL	99	$16,544.50	$14,159.09	$22,419.10	4	69
HARDIN MEMORIAL HOSPITAL	95	$17,599.05	$14,825.93	$21,252.55	4	69

OUR LADY OF BELLEFONTE HOSPITAL	89	$30,843.50	$22,399.70	$36,290.14	3	63
MURRAY-CALLOWAY COUNTY HOSPITAL	85	$24,793.57	$21,218.45	$28,007.80	4	65
REGIONAL MEDICAL CENTER OF HOPKINS COUNTY	84	$23,110.65	$15,961.19	$29,600.07	3	64
JENNIE STUART MEDICAL CENTER	73	$19,953.80	$17,838.61	$22,893.75	3	66
GREENVIEW REGIONAL HOSPITAL	72	$31,805.50	$22,870.80	$39,444.10	4	69
BAPTIST REGIONAL MEDICAL CENTER	70	$31,057.70	$23,958.55	$37,622.13	4	69
LAKE CUMBERLAND REGIONAL HOSPITAL	68	$26,517.50	$20,696.70	$31,353.90	3	66
EPHRAIM MCDOWELL REGIONAL MEDICAL CENTER	63	$23,067.26	$17,119.31	$27,241.77	4	66
FLAGET MEMORIAL HOSPITAL	63	$22,960.50	$18,238.70	$26,366.85	3	68
UNIVERSITY OF KENTUCKY HOSPITAL	57	$27,565.32	$22,332.30	$32,214.20	3	63
UNIVERSITY OF LOUISVILLE HOSPITAL	53	$42,911.29	$23,051.07	$56,154.75	3	55
MARY CHILES HOSPITAL & GATEWAY REGIONAL HEALTH SYSTEM	47	$15,622.53	$13,256.58	$18,385.76	3	62
JACKSON PURCHASE MEDICAL CENTER	45	$25,009.00	$23,473.20	$27,158.20	4	65
PATTIE A CLAY HOSPITAL	38	$25,540.76	$19,755.68	$31,047.09	4	58
FRANKFORT REGIONAL MEDICAL CENTER	37	$32,997.00	$24,276.40	$37,744.00	5	65
BAPTIST NORTHEAST	34	$24,183.11	$17,215.61	$28,148.76	5	62
ARH REGIONAL MEDICAL CENTER - HAZARD	33	$23,446.76	$14,789.71	$29,644.46	3	69
MEADOWVIEW REGIONAL MEDICAL CENTER	31	$22,903.00	$10,965.00	$27,821.00	4	72
ST LUKE HOSPITAL EAST	30	$28,491.41	$20,333.92	$34,366.37	3	75
JEWISH HOSPITAL-SHELBYVILLE	26	$28,717.94	$17,241.65	$33,294.92	4	67
GEORGETOWN COMMUNITY HOSPITAL	23	$26,325.00	$19,340.00	$29,618.40	3	60
METHODIST HOSPITAL	23	$21,848.46	$15,437.03	$27,719.74	4	69
PIKEVILLE METHODIST HOSPITAL	22	$33,385.86	$26,985.21	$36,754.90	4	71
ST LUKE HOSPITAL WEST	22	$28,140.12	$20,085.88	$32,537.64	3	67
SPRING VIEW HOSPITAL	21	$20,798.25	$16,647.25	$32,432.00	4	63

Source: Kentucky Hospital Association Inpatient Database. Report Run Date: 02/01/2006

NOTE: Hospitals with < 20 Discharges for this DRG at this severity level are excluded. A hospital's charges for the 10th percentile and 90th percentile reflect a statistical standard range. About 80% of the time, the hospital's total listed charge will be between the 10th and 90th percentiles. This helps to tell you what is likely to happen within a given hospital. Because these figures are averages, they may be different from what you are billed. The numbers do not measure quality of care.

Hospital Comment Section

JEWISH HOSPITAL - LOUISVILLE

Hospital charges do not indicate how much the hospital is actually paid. Your actual out-of-pocket expense will depend on your insurance benefit plan. For example, Medicare and Medicaid pay a set amount no matter what the hospital's charge. The majority of insurance companies typically pay much less than a hospital's charge.

Jewish Hospital assists patients and families who have difficulty meeting the financial obligations associated with their medical treatment. Programs are provided for both uninsured and under-insured patients. For more information on these programs or questions concerning your health insurance coverage please contact our facility or visit our web site at www.jhhs.org.

5/12/2005

JEWISH HOSPITAL-SHELBYVILLE

Hospital charges do not indicate how much the hospital is actually paid. Your actual out-of-pocket expense will depend on your insurance benefit plan. For example, Medicare and Medicaid pay a set amount no matter what the hospital's charge. The majority of insurance companies typically pay much less than a hospital's charge.

Jewish Hospital Shelbyville assists patients and families who have difficulty meeting the financial obligations associated with their medical treatment. Programs are provided for both uninsured and under-insured patients. For more information on these programs or questions concerning your health insurance coverage please contact our facility.

5/12/2005

KOSAIR CHILDREN'S HOSPITAL

Most of the DRGs in this report do not apply to children. Because Kosair Children's Hospital specializes in pediatric care, its services cannot usually be compared directly to those offered at other hospitals.

4/20/2005

NORTON AUDUBON HOSPITAL

Hospital charges do not indicate how much the hospital is actually paid. A hospital with higher listed charges may not be paid any more than a hospital with lower listed charges. For example, insurance companies typically pay much less than the listed charge, and Medicare pays a set amount, no matter what the hospital's listed charge is.

4/20/2005

NORTON HOSPITAL - LOUISVILLE

Hospital charges do not indicate how much the hospital is actually paid. A hospital with higher listed charges may not be paid any more than a hospital with lower listed charges. For example, insurance companies typically pay much less than the listed charge, and Medicare pays a set amount, no matter what the hospital's listed charge is.

4/20/2005

NORTON SOUTHWEST HOSPITAL - LOUISVILLE

Hospital charges do not indicate how much the hospital is actually paid. A hospital with higher listed charges may not be paid any more than a hospital with lower listed charges. For example, insurance companies typically pay much less than the listed charge, and Medicare pays a set amount, no matter what the hospital's listed charge is.

4/20/2005

NORTON SUBURBAN HOSPITAL

Hospital charges do not indicate how much the hospital is actually paid. A hospital with higher listed charges may not be paid any more than a hospital with lower listed charges. For example, insurance companies typically pay much less than the listed charge, and Medicare pays a set amount, no matter what the hospital's listed charge is.

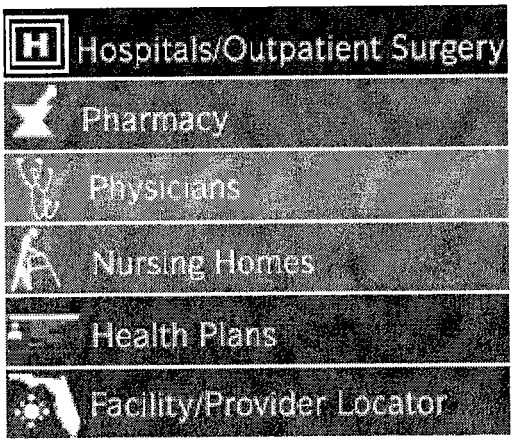
4/20/2005

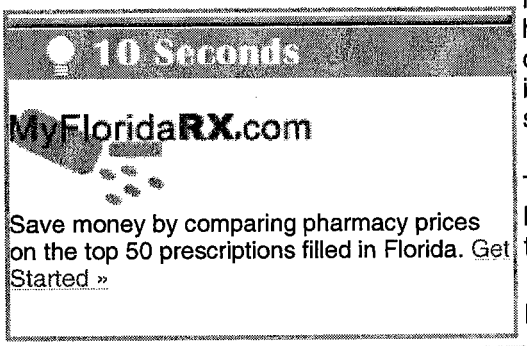
TAYLOR COUNTY HOSPITAL

Hospital charges do not indicate how much the hospital is actually paid. Your actual out-of-pocket expense will depend on your insurance benefit plan. For example, Medicare and Medicaid pay a set amount no matter what the hospital's charge. The majority of insurance companies typically pay much less than a hospital's charge.

Taylor County Regional assists patients and families who have difficulty meeting the financial obligations associated with their medical treatment. Programs are provided for both uninsured and under-insured patients. For more information on these programs or questions concerning your health insurance coverage please contact our facility.

5/12/2005





A Message from Secretary Alan Levine

Welcome to Florida's health care data site, the leading edge for state information.

The Agency for Health Care Administration's (AHCA) redesigned wet an ambitious program. This site will ultimately give Florida's health ca purchasers and professionals an unprecedented degree of easy-to-a understandable information on quality, pricing and performance. Goo making sure our health care system works well and in everyone's inte committed to delivering information that is practical and useful, can pl driving improvements in quality, and can help reduce exploding healtl

While this site already has many resources, the 2004 Florida Legislat make more information readily available to consumers. You can find l facilities and providers, information on Medicare, Medicaid, health ins hospital and ambulatory facility data, and more. We'll continue to exp considerably in the near future, and we'll do our best to streamline yo information. Don't hesitate to offer feedback: what you like, what you see.

The future of health care will come from better information. The Agen has finally come to make health care more transparent. We recognize the people of this state and we take this challenge very seriously.

Here's to better health care for all Floridians!

Additional AHCA Information

- **State Center for Health Statistics - Annual Report** New
- AHCA Press Releases
- Comprehensive Health Information System (CHIS) Advisory Council
- **Emergency Department Utilization Report** New
- Florida's Health Information Infrastructure
- Florida Medicaid
- Florida Organ and Tissue Donor Program
- Frequently Inquired Topics
- HIPAA
- Health Flex
- Health Links
- **HMO Report 2005** New
- Order Data
- State of Florida Health Dat
- Nursing Home Guide
- Patient's Bill of Rights

Florida Compare Care

X = less than 30 cases; also indicates the facility may not perform this service.

Category: Orthopedic (Bones)
Condition/Procedure: Hip Replacement, Total
Time Period: January 2004 through December 2004

Facility / City	Total Hospitalizations	Risk Adjusted Average Charge	Risk Adjusted Average Length of Stay
STATEWIDE	**14,454**	**$45,568**	**4.2 days**
All Children's Hospital - 100250 St. Petersburg	X	X	X
Anne Bates Leach Eye Hospital - 100240 Miami	X	X	X
Arnold Palmer Hospital for Children & Women - 120001 Orlando	X	X	X
Aventura Hospital and Medical Center - 100131 Aventura	45	$41,230	3.3 days
Baptist Hospital - 100093 Pensacola	38	$35,984	4.3 days
Baptist Hospital of Miami - 100008 Miami	213	$43,326	3.7 days
Baptist Medical Center - 100088 Jacksonville	163	$37,482	3.2 days
Baptist Medical Center Beaches - 100117 Jacksonville Beach	57	$37,334	3.5 days
Baptist Medical Center Nassau - 100140 Fernandina Beach	X	X	X
Bartow Regional Medical Center - 100121 Bartow	X	X	X
Bay Medical Center - 100026 Panama City	34	$37,285	3.8 days
Bayfront Medical Center - 100032 St. Petersburg	118	$58,724	4.2 days
Bert Fish Medical Center - 100014 New Smyrna Beach	40	$34,168	4.0 days
Bethesda Memorial Hospital - 100002 Boynton Beach	87	$39,556	3.3 days
Blake Medical Center - 100213 Bradenton	172	$49,029	3.5 days
Boca Raton Community Hospital - 100168 Boca Raton	269	$26,864	3.2 days

Massachusetts Health Care Quality and Cost Information

Hip Replacement Mortality (FY04), by Hospital

Legend

★ Mortality significantly higher than state average
★★ Mortality as expected
★★★ Mortality significantly lower than state average

$ Hospitals with lowest 25% of costs
$$ Hospitals in middle 50% of costs
$$$ Hospitals with highest 25% of costs

Hospital Name	Quality	Cost	Total Cases	Days in Hospital
Total Massachusetts Hip Replacement cases			5,612	
MetroWest M.C.— Framingham Campus	Rates not calculated for hospitals with fewer than 30 cases.			
MetroWest M.C.— Leonard Morse Campus	Rates not calculated for hospitals with fewer than 30 cases.			
Milford Regional Medical Center	★★	$$	50	4
Milton Hospital	Rates not calculated for hospitals with fewer than 30 cases.			
Morton Hospital	★★	$$	33	4
Mount Auburn Hospital	★★	$$$	82	3
Nantucket Cottage Hospital	Rates not calculated for hospitals with fewer than 30 cases.			
Nashoba Valley Medical Center	Rates not calculated for hospitals with fewer than 30 cases.			
New England Baptist Hospital	★★	$$$	1212	4
Newton-Wellesley Hospital	★★	$$	92	4
Noble Hospital	Rates not calculated for hospitals with fewer than 30 cases.			
North Adams Regional Hospital	Rates not calculated for hospitals with fewer than 30 cases.			
North Shore M.C. — Salem Campus	★★	$$$	114	5
North Shore M.C. — Union Campus	★★	$$	57	4
Northeast H.S. — Addison Gilbert Campus	Rates not calculated for hospitals with fewer than 30 cases.			
Northeast H.S. — Beverly Campus	★★	$$	133	4
Quincy Medical Center	Rates not calculated for hospitals with fewer than 30 cases.			
Saint Anne's Hospital	Rates not calculated for hospitals with fewer than 30 cases.			
Saint Vincent Hospital	★★	$	67	4
Saints Memorial Medical Center	★★	$$	45	4
South Shore Hospital	★★	$$	113	4
Southcoast Hospitals Grp. — Charlton Memorial Campus	★★	$$	76	5
Southcoast Hospitals Grp. — St. Luke's Campus	★★	$$	82	6
Southcoast Hospitals Grp. — Tobey Campus	Rates not calculated for hospitals with fewer than 30 cases.			
Sturdy Memorial Hospital	Rates not calculated for hospitals with fewer than 30 cases.			
Tufts-New England Medical Center (NEMC)	★★	$$$	36	4
UMass Memorial Medical Center	★★	$$$	327	3
Winchester Hospital	★	$$	76	3
Wing Memorial Hospital	Rates not calculated for hospitals with fewer than 30 cases.			

Notes:
Source: DHCFP Hospital Discharge Data and 403 Hospital Cost Report
Complexity rates (Case-Mix Index) no statistical variation across hospitals.